Focus on the Process: REQUIREMENTS for the Transformation to Evidence-Based Practice…

CDR Cynthia J. Gantt NC, USN, FNP, PhD
TRICARE Management Activity

CDR Maureen Padden MC, USN, MD, MPH
Camp Lejeune Family Medicine Residency

“Beyond the CPGs”

Objectives

1. Explain the cultural changes required to practice evidence-based health care.
2. Understand the “whys” of using the “MTF Road Map for Successful Disease & Condition Management” as a means to effect these cultural changes.
3. Understand “how” the **MTF Road Map** is used to *transform* **and** *sustain* evidence-based practice at the **clinic level.**

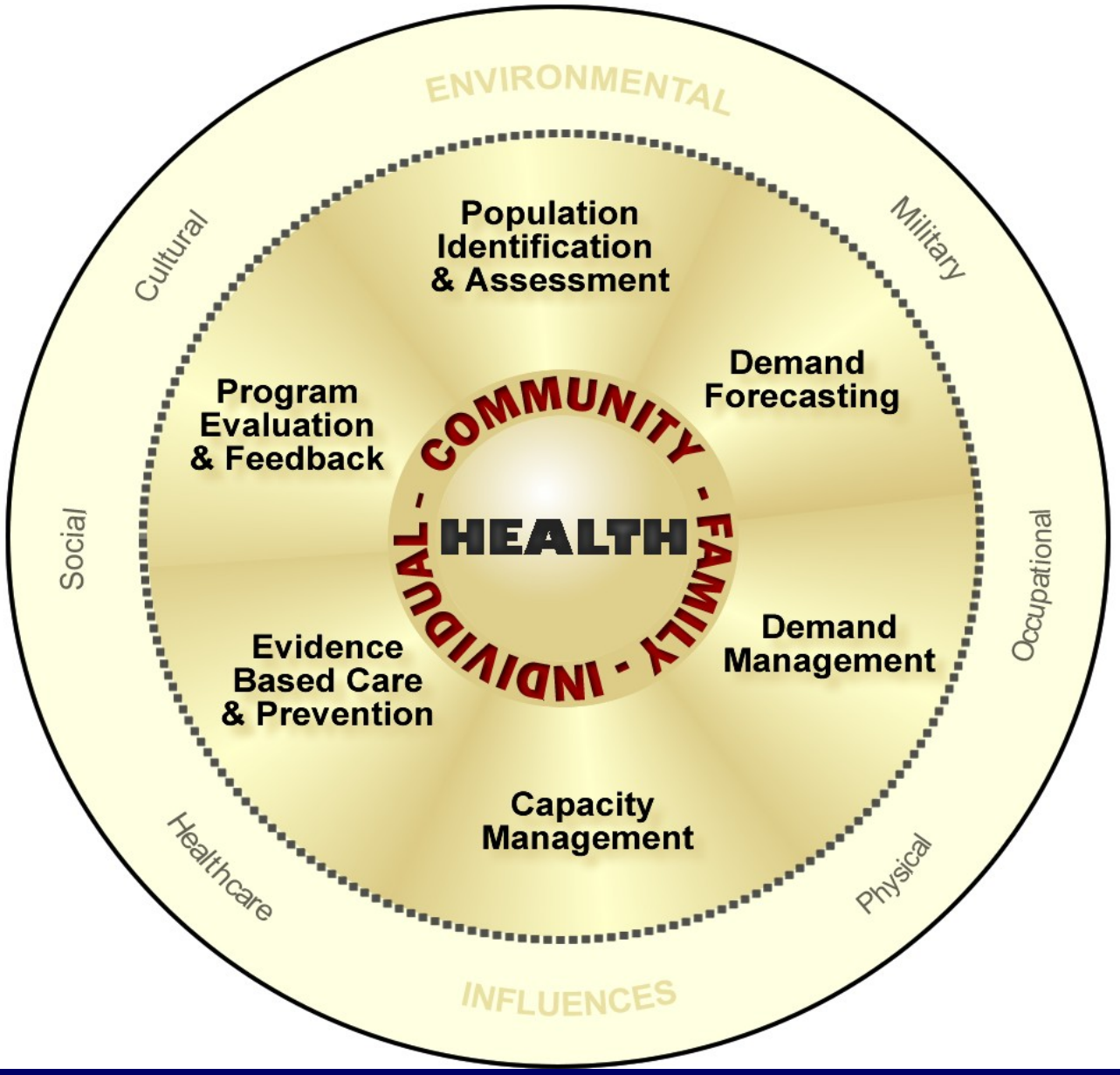
System-wide Alignment, Commitment and Support

- Congress requires a “Population Health” approach to health care in the DoD (2006 National Defense Authorization Act)
- Military Health System (MHS) Quadrennial Defense Review (QDR)
  - Initiative #17: “Effective Patient Partnerships”: Includes evidence based care and disease management
- MHS Strategic Plan
  - Our care will be patient centered, using evidence based interventions

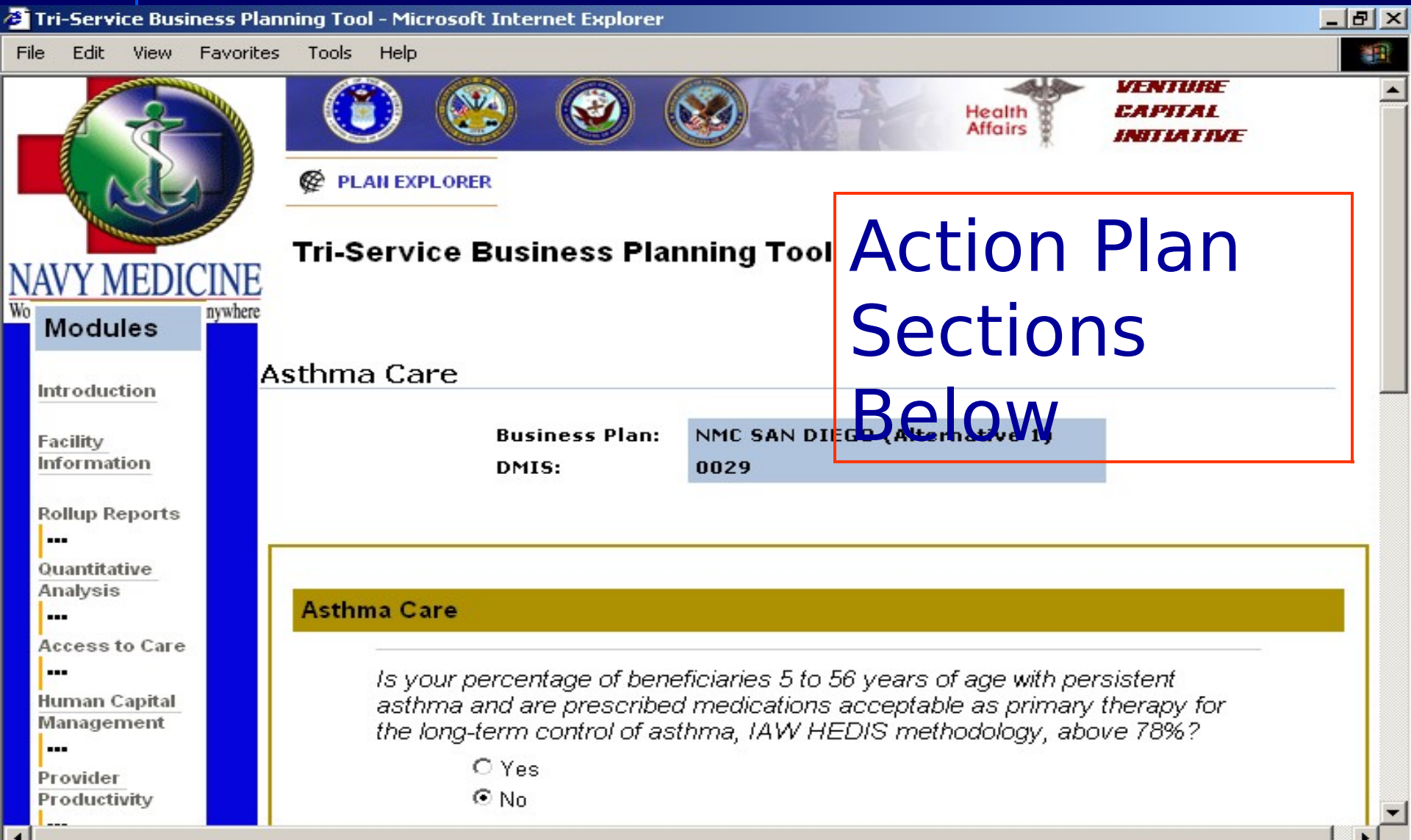
System-wide Alignment, Commitment and Support

- Tri-Service/BUMED Business Plans
  - System-wide clinical metrics: Diabetes, Asthma, Breast Health
  - Comparisons between MTFs, clinics, PCMs
- BUMED NOTICE 6310
  - "FY 2006 NAVY MEDICINE AND CONDITION MANAGEMENT PROGRAM"
- This training!

Military Health System Population Health Model



Evidence-Based Healthcare Section Business Plan



Required System-Wide Cultural Changes

Then…

- Confined to physicians & other providers, "in isolation"
- "Imposed from above"

Now…

- "Buy In" = Entire Health Care TEAM
  - Expanded roles: exciting, yet stressful for some
- Multidisciplinary involvement
  - From the earliest stages
    - Input = increased cooperation; more innovations

[1] **Bodenheimer, T, Wagner, E. H., & Grumbach, K. (2002)**

Required System-Wide Cultural Changes…

Then…

- "Tyranny of the Urgent"[1]
- Suboptimal Portals of Care
  - Emergency Department
  - Inpatient crises
- Reactive to pts who make appts or have already been seen

Now…

- Disease & Condition Management
  - Planned visits for preventive & chronic care
- **PROACTIVELY** calling & bringing patients into clinic
  - Requires changes in business processes:

  Who?

  How? (e.g., order sets)

[1] **Bodenheimer, T, Wagner, E. H., &**

More Required System-Wide Cultural Changes: Tools

Then…

- Some great "home-grown" Disease Management databases
- Limitations: Time-consuming, no visibility of patients who were not seeking care, unable to access results from other Commands

Now…

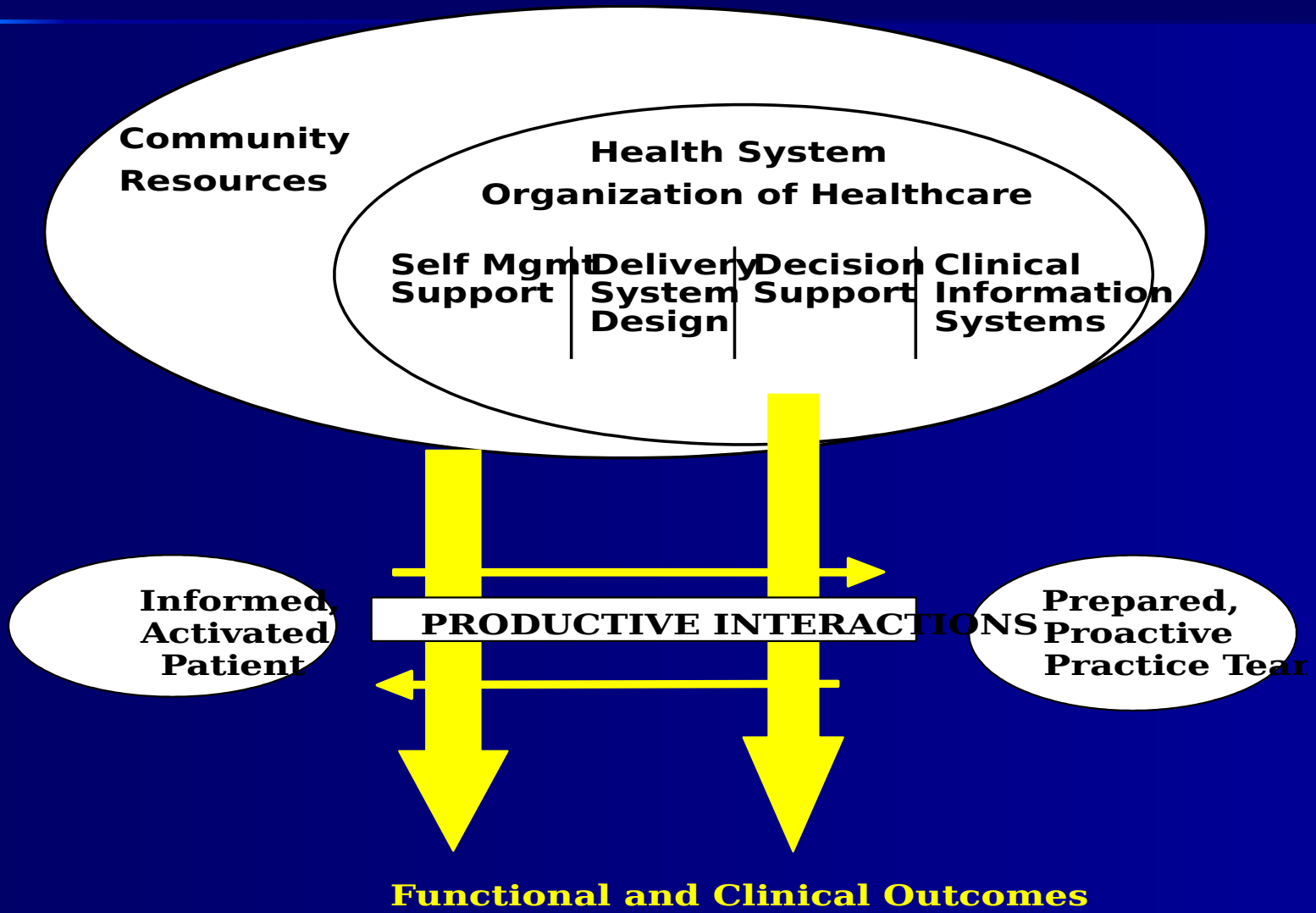
- Population Health Navigator (PHN) tool:
  - Uniform methodologies
  - Auto-populated
  - Identifies patients by Clinic & PCM
  - Patient-centered; Global
  - Supports the move toward a "Proactive Clinical Practice" model

"Framework Required"… Chronic Care Model

- Community Resources & Policies
- Health System Organization of Health Care
- Self-management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems

Wagner, E. H. (2001). Meeting the needs of chronically ill people. BMJ, 323, 945-6.

Chronic Care Model



"MTF Road Map for Successful Disease & Condition Management"

- Leadership
- Clinical Practice Guidelines & Metrics
- Disease & Condition Management Reengineering
- Program Deployment & Evaluation
- Education
- Marketing

Meyers & Padden (2001)

1. Leadership (Support)

ALL LEVELS!

- Directors (Governing Board/ESC) provide oversight & support
  - Command's strategic plan
  - Periodic formal evaluation
  - Analyze return on investment & cost avoidance
- Clinical Champions & Program Coordinators
  - Formal (chartered) disease/condition specific teams
- Department Heads
- Physician Clinical Opinion Leaders

2. Clinical Practice Guidelines & Metrics

"Systematically developed statements to assist practitioner & patient decisions about appropriate health care services for specific clinical circumstances."

Institute of Medicine, 1992

- Ensure predictable/ consistent quality
- Improve resource utilization
- Guide learning (pts & staff)
- Reduce variation & errors (pt safety)
- Assure appropriate amount of care
- Ensure accountability

Metrics: "How do you know what you are doing is working?"

Health Industry Standards

HEDIS®: Health Plan Employer Data and Information Set

- HEDIS® is a set of performance measures that compare how well health plans perform in key areas:
  - Quality of care
  - Access to care
  - Member satisfaction with health plan & providers

Why HEDIS®?

- Used by majority of health plans to measure performance on dimensions of care and service
- Provide consumers with information they need to compare plans
- Selected by BUMED to compare ALL MTF's for specific disease conditions
- Integrated into the business rules for the Population Health Navigator

Example: Current Diabetic Care at a MTF

74% of all *continuously* enrolled diabetics, age 18-75, had an A1c in the past 12 months

- **Performance Metric:**
  - **HEDIS**: All diabetics should receive at least one A1c test in the past 12 mos
- **Performance Benchmark:**
  - **HEDIS:** Compare your clinic's % to the HEDIS 90th percentile benchmark of 90.6%
- **Clinical Benchmark:**
  - **ADA & VHA/DoD:** Diabetics should receive A1c tests every 4 months**

3. Disease Management Reengineering

- "Where the rubber meets the road…& many folks get stuck"
- Clinical AND business processes reviewed
  - Multidisciplinary perspective required!
  - Teambuilding skills a must
  - Process mapping, patient-centered flow charting
- Reengineered to optimize existing staffing & resources: "WHO is going to contact these patients?"
  - Health care team (e.g., nurses, pharmacists) clinics
  - Group visits

Tri-Service Clinical Informatics Tool

NAVY Population Health Navigator

- Web-based standardized reports, including patient action lists by clinic and by PCM
- HEDIS methodologies & national benchmarks
- Follows patient throughout MHS (over multiple CHCS/AHLTA MTF host sites) and includes network claims data!

4. Program Deployment & Evaluation

- Plan for effective deployment
- Internal (staff) and External (patients):
  - Aware and knowledgeable about the program
  - Roles of the individual staff members are clarified (formal clinic management team structure helps a lot!)
- CONTINUOUS process (PDCA/PDSA) in place to monitor performance of the program

5. Education

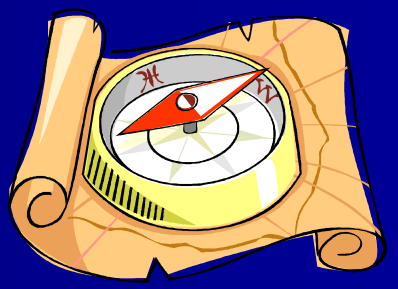
- Staff and provider education
  - New disease/condition management business processes
  - On-line BUMED toolkits
- Education is provided along with feedback on performance to the care **team**
- Providers not meeting standards are reviewed & mentored by clinical champions
- Patient education regarding clinical processes (CPG) and self-management

6. Marketing

- Specific marketing plan to providers <u>AND patients</u>
  - Do not leave until the last minute!
  - Have an official “Kick-Off”
  - Get leadership’s support and official endorsements
  - NEVERENDING!

What the Road Map Can Do For You & Your Command

- Organize (do more things simultaneously)
- Prioritize required actions
- More effectively communicate & educate
  - "Up" AND "Down" the chain
- Monitor Progress
- Sustain (despite deployments, rotations)
  - "Turnover Tool"
- Expand to other conditions!



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- MHS Population Health and Medical Management Support Center: www.mhsophsc.org
- DoD Medical Management Guide: Disease Management www.mhsophsc.org/public/spd.cfm?spi=mmguide

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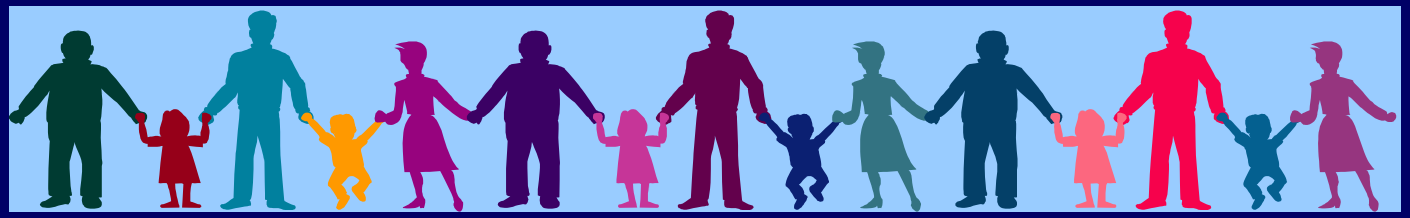

Next:

Putting the MTF Road Map to Work…
the Case Study